



HEALTH FAIR CLAIM FORM

Provider Name	
Provider Tax ID Number	
School District	
MUST Member Social Security Number	
Patient Name	
Patient Date of Birth	
Assignment of Benefits	**Please pay claimant**

DATE OF SERVICE	PLACE OF SERVICE	CPT CODE	ICD-9	CHARGE
			V70.0	
			V70.0	
			V70.0	

Benefits will be payable in accordance with the benefits provided by your MUST health plan. In order to maximize your benefits, it will be necessary to complete all blanks. Please submit a separate claim form for each family member.

Member Signature: _____

Date: _____

Mail to: MUST Claims
P.O. Box 3777
Missoula, MT 59806-3777

Or fax to: 1-406-523-3111